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No. 84098-9

BY RONALD R. CARPENTER

~~IN THE SUPREME COURT OF THE STATE OF WASHINGTON~~
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BREEAN BEGGS, as Personal Representative for the estate of TYLER
DELEON and as Limited Guardian Ad Litem for DENAE DELEON,
BREANNA DELEON, LAKAYLA DELEON, ANTHONY
BARCELLOS and BRENDEN BURNETT, minor children; FRANCES
CUDMORE as Limited Guardian Ad Litem for BECKETT CUDMORE, a
minor child; and AMBER DANIELS, a single individual,

Plaintiffs/Petitioners,

vs.

DAVID FREGEAU, M.D.; the ROCKWOOD CLINIC, a Washington
State corporation; SANDRA BREMNER-DEXTER, M.D.,

Defendants/Respondents.

BRIEF OF AMICUS CURIAE
WASHINGTON STATE ASSOCIATION FOR JUSTICE FOUNDATION

George M. Ahrend
WSBA No. 25160
100 E. Broadway Ave.
Moses Lake, WA 98837
(509) 764-9000

Bryan P. Harnetiaux
WSBA No. 5169
517 E. 17th Avenue
Spokane, WA 99203
(509) 624-3890

On Behalf of
Washington State Association for Justice Foundation

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I. IDENTITY AND INTEREST OF AMICUS CURIAE

The Washington State Association for Justice Foundation (WSAJ Foundation) is a not-for-profit corporation organized under Washington law, and a supporting organization to the Washington State Association for Justice (WSAJ). WSAJ Foundation is the new name of Washington State Trial Lawyers Association Foundation (WSTLA Foundation), a supporting organization to the Washington State Trial Lawyers Association (WSTLA), now renamed WSAJ. These name changes were effective January 1, 2009.

WSAJ Foundation, which operates the amicus curiae program formerly operated by WSTLA Foundation, has an interest in the rights of plaintiffs under the civil justice system, including an interest in clarifying the relationship between claims for injury under the mandatory child abuse reporting statute, RCW 26.44.030, and claims for injury as a result of health care under Ch. 7.70 RCW, as well as an interest in the proper interpretation and application of the dependent for support requirement for second-tier beneficiaries under the wrongful death and survival statutes, RCW 4.20.020, RCW 4.20.046 and RCW 4.20.060.

II. INTRODUCTION AND STATEMENT OF THE CASE

This case involves (1) the relationship between claims for failure to comply with the mandatory child abuse reporting statute, RCW 26.44.030,

and claims for injury as a result of health care under Ch. 7.70 RCW; and (2) the proper interpretive lens for determining whether parties qualify as second-tier beneficiaries entitled to recover non-economic damages under the wrongful death and survival statutes, RCW 4.20.020, .046 and .060.¹

Breean Beggs, as the personal representative of the estate of Tyler DeLeon, and Tyler's adoptive siblings (Beggs) filed suit against Tyler's former health care providers, David Fregeau, M.D., the Rockwood Clinic, and Sandra Bremner-Dexter, M.D., for negligent failure to report that Tyler was abused by his adoptive mother. Tyler later died as a result of continued abuse. He was seven years old.

Beggs alleged a claim against the health care providers for failure to comply with the mandatory child abuse reporting statute, RCW 26.44.030, as well as a claim for medical negligence under Ch. 7.70 RCW, presumably based on the same conduct. Beggs sought to recover non-economic damages under the wrongful death and survival statutes, on grounds that adoption support payments that Tyler's adoptive mother received on his behalf from the Washington State Department of Social and Health Services (DSHS) rendered Tyler's adoptive siblings financially dependent on him for support.

¹ The facts relevant to this amicus curiae brief are drawn from the briefing of the parties. See Beggs App. Br. at 3-9; Health Care Providers (HCP) Resp. Br. at 1-4.

The health care providers filed two motions for partial summary judgment. They sought dismissal of the claim based on noncompliance with RCW 26.44.030, arguing that any civil remedy was governed by Ch. 7.70 RCW. They also sought dismissal of the wrongful death and survival actions to the extent Beggs made claims for non-economic damages, arguing that adoption support payments received by Tyler's adoptive mother did not render his adoptive siblings dependent upon him for support because the payments were not voluntarily made by Tyler, nor were they supposed to be used for the support of his adoptive siblings.

The trial court granted both of the health care providers' summary judgment motions, and Beggs petitioned for discretionary review before the Court of Appeals, Division III. The court granted review on both summary judgment orders, and then certified the case to this Court for decision.

III. ISSUES PRESENTED

- 1.) May a plaintiff bring a freestanding tort action against health care providers under RCW 26.44.030, the mandatory child abuse reporting statute, or is a claim for negligent failure to report suspected child abuse subsumed by Ch. 7.70 RCW?
- 2.) In interpreting the dependent for support requirement for second-tier beneficiaries under RCW 4.20.020, .046 and .060, are the statutes subject to a liberal or strict construction?

IV. SUMMARY OF ARGUMENT

Re: RCW 26.44.030 & Ch. 7.70 RCW

Chapter 26.44 RCW provides extraordinary and needed protection from abuse for Washington's children. Victimized children and their beneficiaries may pursue a tort action based upon RCW 26.44.030 for failure to report child abuse against a health care provider, and this type of claim is not subsumed by Ch. 7.70 RCW, governing medical negligence claims against health care providers. Failure to report suspected child abuse to proper authorities should not be viewed "as a result of health care" under Ch. 7.70 RCW, and, consequently, that chapter is inapplicable. In addition, Ch. 26.44 RCW and Ch. 7.70 RCW address distinct issues and protect different values. A health care provider's obligation to report suspected child abuse under Ch. 26.44 RCW's "reasonable cause to believe" standard focuses on protecting children while a provider's compliance with the standard of care under Ch. 7.70 RCW focuses on assuring competent medical treatment.

Re: Interpretation of RCW 4.20.020, .046 and .060

The wrongful death and survival statutes should be liberally construed to effectuate their remedial purposes, in accordance with the Court's modern view of these statutes, represented by Armijo v. Wesselius, 73 Wn.2d 716, 440 P.2d 71 (1968). The Court should

expressly reject the strict construction analysis in Whittlesey v. Seattle, 94 Wash. 645, 163 Pac. 193 (1917), insofar as it is inconsistent.

V. ARGUMENT

A. **The Implied Cause Of Action Under RCW 26.44.030 For Failure To Report Child Abuse Is A Freestanding Claim, Separate And Distinct From A Medical Negligence Claim Under Ch. 7.70 RCW.**

Chapter 26.44 RCW addresses the “Abuse of Children.” Its mandatory child abuse reporting statute provides in pertinent part:

When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department[of social and health services.]

RCW 26.44.030(1)(a) (emphasis added). The statute imposes an obligation to report suspected child abuse, so that appropriate authorities can investigate, and, if warranted, offer protective services to prevent further abuse. The declaration of purpose for Ch. 26.44 RCW states:

The Washington state legislature finds and declares: The bond between a child and his or her parent, custodian, or guardian is of paramount importance, and any intervention into the life of a child is also an intervention into the life of the parent, custodian, or guardian; however, instances of nonaccidental injury, neglect, death, sexual

abuse and cruelty to children by their parents, custodians or guardians have occurred, and in the instance where a child is deprived of his or her right to conditions of minimal nurture, health, and safety, the state is justified in emergency intervention based upon verified information; and therefore the Washington state legislature hereby provides for the reporting of such cases to the appropriate public authorities. It is the intent of the legislature that, as a result of such reports, protective services shall be made available in an effort to prevent further abuses, and to safeguard the general welfare of such children[.]

RCW 26.44.010. The Legislature bolstered this declaration in connection with the 1985 amendment to RCW 26.44.030:

The children of the state of Washington are the state's greatest resource and the greatest source of wealth to the state of Washington. Children of all ages must be protected from child abuse. *Governmental authorities must give the prevention, treatment, and punishment of child abuse the highest priority, and all instances of child abuse must be reported to the proper authorities who should diligently and expeditiously take appropriate action[.]*

1985 Laws ch. 259 § 1 (uncodified; emphasis added); see also C.J.C. v. Catholic Bishop, 138 Wn.2d 699, 727 & n.16, 985 P.2d 262 (1999) (lead opinion recognizing public policy).²

The strength of the policy underlying the mandatory child abuse reporting statute is evidenced by the fact that the duty to report imposed on certain professionals, including health care providers, trumps applicable evidentiary privileges. See RCW 26.44.030(1)(b); RCW 26.44.060(3). It is also confirmed by the fact that knowing failure to

² The uncodified declaration of purpose for the 1985 amendments to Ch. 26.44 RCW is reproduced in the Appendix to this brief.

report child abuse is a crime, while mandatory reporters are given immunity from liability for good faith reports. See RCW 26.44.060(1)(a); RCW 26.44.080.³ In fact, Ch. 26.44 RCW in its entirety furthers the policy of protecting Washington’s children.

The mandatory reporting statute creates an implied private cause of action for failure to report suspected child abuse. See Jane Doe v. Latter-Day Saints, 141 Wn.App. 407, 423, 167 P.3d 1193 (2007), *review denied*, 164 Wn.2d 1009 (2008). The private cause of action “is consistent with the underlying intent of the statute—imposing civil consequences for failure to report motivates mandatory reporters to take action to protect victims[.]” Id. at 423.⁴

The parties in this case do not question the existence or validity of the mandatory duty to report suspected child abuse, or its applicability to health care providers. See RCW 26.44.020(15) (defining “practitioner”). Nor do the parties disagree on the existence or validity of the implied cause of action under RCW 26.44.030 for failure to report, recognized in Jane Doe. Instead, the health care providers question whether the cause of

³ The current versions of RCW 26.44.010, .020, .030, .060 and .080 are reproduced in the Appendix to this brief.

⁴ Although the remainder of the quotation from Jane Doe, 141 Wn.App. at 423, is phrased in terms of protecting victims of childhood *sexual* abuse, the mandatory reporting statute encompasses both sexual and non-sexual child abuse. See RCW 26.44.020(1) (defining “abuse or neglect”). The policies underlying the statute and the implied private cause of action are equally applicable in cases of non-sexual abuse.

action is available as an independent claim against a health care provider in light of the subsequent adoption of Ch. 7.70 RCW. The reporting statute was originally adopted in 1965, and it was made mandatory for physicians and others six years later. See 1965 Laws ch. 13 § 3; 1971 Laws, 1st Ex. Sess., ch. 217 § 3. Chapter 7.70 RCW was first enacted effective June 25, 1976. See 1975-1976 Laws, 2nd Ex. Sess., ch. 56 § 6.

Under Ch. 7.70 RCW:

The state of Washington, exercising its police and sovereign power, hereby modifies as set forth in this chapter and in RCW 4.16.350, as now or hereafter amended, certain substantive and procedural aspects of *all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care* which is provided after June 25, 1976.

RCW 7.70.010 (emphasis added). Based on this provision, the health care providers argue:

The legislature is presumed to enact laws with full knowledge of existing laws. *Thurston County v. Gorton*, 85 Wn.2d 133, 530 P.2d 309 (1975). Thus, when the legislature enacted RCW 7.70 governing all civil actions against healthcare providers for damages occurring as a result of healthcare, it did so knowing that any claim for negligence in the diagnosis and reporting of child abuse would be deemed to be included in RCW 7.70.

See HCP Resp. Br. at 13. Thus, while the health care providers do not question Jane Doe or the private cause of action recognized therein, they attempt to distinguish the case on grounds that it does not involve a claim against a health care provider. See HCP Resp. Br. at 15-16.

The health care providers draw the incorrect inference from the adoption of Ch. 7.70 RCW, and their resulting attempt to distinguish Jane Doe is misguided. It is at best a fiction that the Legislature intended, when it adopted Ch. 7.70 RCW in 1976, to include a Ch. 26.44-based cause of action that was not recognized until 30 years later.

While it is true that the Legislature is presumed to be aware of existing laws, the lack of any specific indication that it intended to supersede or eliminate provisions of existing law should support the exact opposite inference from the one drawn by the health care providers. See Gorton, 85 Wn.2d at 138; see also State v. Conte, 159 Wn.2d 797, 808, 154 P.3d 194 (recognizing that Legislature is presumed to have knowledge of existing statutes, and finding prior statute effective in absence of “express indicator” to the contrary in later statute), *cert. denied*, 552 U.S. 992 (2007).

For example, in Bundrick v. Stewart, 128 Wn.App. 11, 16-18, 114 P.3d 1204 (2005), while noting the presumption that the Legislature is aware of existing laws, the Court of Appeals held that Ch. 7.70 RCW does not supersede or eliminate common law claims for medical battery because “nothing in the statute indicates the Legislature intended to eliminate the common law claim.” Id., 128 Wn.App. at 17. Likewise, there is nothing in Ch. 7.70 RCW that indicates the Legislature intended to

preempt judicial recognition of an independent cause of action against health care providers based on the mandatory reporting statute.⁵

More importantly, Ch. 7.70 RCW does not supersede or eliminate different claims that serve to protect different values. In Bundrick the Court of Appeals noted that a common law claim for medical battery is not superseded or eliminated by Ch. 7.70 RCW because the different claims protect entirely different values. See id. at 17 (holding informed consent claim under Ch. 7.70 RCW “protects the patient’s right to know the risks of the decisions she makes about her care, whereas the cause of action for common law battery protects an individual’s right to privacy and bodily integrity”).

In this respect, Bundrick is consistent with Reese v. Sears, Roebuck & Co., 107 W.2d 563, 571-72, 731 P.2d 497 (1987), *overruled on other grounds*, Phillips v. Seattle, 111 Wn.2d 903, 766 P.2d 1099 (1989), and Goodman v. Boeing Co., 127 Wn.2d 401, 404-06, 899 P.2d 1265 (1995), where the Court held that legislative enactments serving distinct purposes or remedying distinct injuries should both be given

⁵ Bundrick is supported by Berger v. Sonneland, 144 Wn.2d 91, 26 P.3d 257 (2001), where the Court held that the Uniform Health Care Information Act, Ch. 70.02 RCW (UHCIA), did not supersede or eliminate statutory claims for a health care provider’s unauthorized disclosure of a patient’s confidential information under Ch. 7.70 RCW, even though enacted after Ch. 7.70 RCW, because the text of the UHCIA contains no language indicating that the Legislature intended it to be exclusive. See id., 144 Wn.2d at 105. The Court had not previously held that such claim was available under Ch. 7.70 RCW. See id. at 106 & n.73.

effect, even if one of them purports to be “exclusive.” In Reese, 107 Wn.2d at 571-72, the Court held that the exclusive remedy provisions of the Industrial Insurance Act, Title 51 RCW, did not prevent injured workers from bringing disability discrimination claims against their employers under the Washington Law Against Discrimination, Ch. 49.60 RCW (WLAD), even though the underlying disabilities arose from a workplace injury. Subsequently, in Goodman, 127 Wn.2d at 404-06, the Court held that the worker could bring claims for aggravation of a prior workplace injury/disability based on a separate violation of the WLAD.

The same type of analysis should be applied to the mandatory reporting statute, which protects different values than a medical negligence claim under Ch. 7.70 RCW. Chapter 7.70 RCW protects a patient’s interest in obtaining competent health care consistent with the standard of care, the provider’s promises, and the patient’s wishes. See RCW 7.70.030(1)-(3). On the other hand, the mandatory child abuse reporting statute and implied cause of action recognized thereunder protect children from suffering continued abuse. In other words, Ch. 7.70 RCW is about treatment, while Ch. 26.44 RCW is about protection. Accordingly, claims against health care providers for failure to report suspected child abuse under RCW 26.44.030 should not be subsumed by Ch. 7.70 RCW.

In light of this policy-based analysis, the availability of claims against health care providers distinct from Ch. 7.70 RCW does not necessarily hinge on the characterization of the act for which liability is imposed as health care. By its terms, the scope of Ch. 7.70 RCW applies to claims “for damages for injury occurring as a result of health care.” RCW 7.70.010. If a claim is not the “result of health care,” then Ch. 7.70 RCW clearly does not apply. For example, in Estate of Sly v. Linville, 75 Wn.App. 431, 440, 878 P.2d 1241 (1994), involving a claim for negligent misrepresentation by the health care provider in the course of the physician-patient relationship, the Court of Appeals held:

The claim results not from health care but from misrepresentations made by [Dr.] Linville. In other words, Linville’s breach of duty did not arise during the process in which he was “utilizing the skills which he had been taught in examining, diagnosing, treating or caring for” Sly[.]

In this same sense, the alleged breach of the duty to report suspected child abuse may be occasioned by the provision of health care, but it is not part of the function of the health care provider in examining, diagnosing, or treating the patient, and thus is outside of Ch. 7.70 RCW.⁶

⁶ The health care providers incorrectly characterize the misrepresentations in Sly as “intentional.” See HCP Resp. Br. at 16; Sly, 75 Wn.App. at 433 (stating health care provider “appeal[ed] the judgment against him for negligent misrepresentation”); see also Young v. Savidge, 155 Wn.App. 806, 821-22, 230 P.2d 222 (2010) (recognizing independent claim for *intentional* misrepresentation against health care provider).

Under the policy-based analysis described above, even when claims arise from health care, policy considerations may justify recognition of an independent claim outside of Ch. 7.70 RCW. For example, it cannot seriously be disputed that the claim for medical battery based on a total lack of informed consent at issue in Bundrick could have been viewed as an action “for damages for injury occurring as a result of health care.”⁷

On the other hand, the health care providers’ argument is grounded solely in the definition of health care. They characterize “any medical conclusion ... as to potential abuse, and any corresponding duty to report it” as health care, i.e., “the process of utilizing the skills of examining, diagnosing, treating or caring for the patient.” See HCP Resp. Br. at 14 (paraphrasing definition of “health care” from Branom v. State, 94 Wn.App. 964, 969-70, 974 P.2d 335, *review denied*, 138 Wn.2d 1023 (1999)). On this basis, they argue that a claim for failure to report child abuse must be brought under Ch. 7.70 RCW, requiring a violation of the

⁷ See also Wright v. Jeckle, 104 Wn.App. 478, 483-84, 16 P.3d 1268 (suggesting overlap between medical negligence and independent Consumer Protection Act claims by stating that “the mere fact that advice is given, or representations made, does not rule out the possibility that they may in fact implicate the entrepreneurial aspects of the professional relationship,” and allowing CPA claim against physician to proceed because it was a question of fact whether physician was engaged in the practice of medicine or the business of selling diet drugs), *review denied*, 144 Wn.2d 1011 (2001); Young, 155 Wn.App. at 821-22 & n.11 (stating “Washington courts analyze medical malpractice claims apart from common law intentional tort claims even when those torts arise under

standard of care and compliance with the other requirements of the chapter, requirements that are not explicitly imposed under Ch. 26.44 RCW. See HCP Resp. Br. at 14-15.⁸

Stretching the definition of health care to include reports of child abuse naturally raises the question whether any non-health care provider subject to the mandatory reporting statute is, in effect, also rendering health care when he or she makes the report. The fact that these non-health care providers are equally subject to the requirements of the mandatory reporting statute militates against framing reports of suspected child abuse as health care for those reporters subject to Ch. 7.70 RCW.⁹

‘health care,’” discussing Bundrick, Wright, and Doe v. Finch, 133 Wn.2d 96, 100, 942 P.2d 359 (1997), which involved overlapping claims for outrage and medical negligence).

⁸ While the Court has recently struck down certain prerequisites as unconstitutional, see Waples v. Yi, 169 Wn.2d 152, 234 P.3d 187 (2010) (presuit notice of claim), and Putman v. Wenatchee Valley Med. Ctr., 166 Wn.2d 974, 216 P.3d 374 (2009) (certificate of merit), other unique requirements remain. See e.g. RCW 4.16.350 (statute of limitations and repose); RCW 7.70.030 (describing nature of claim and standard of proof); RCW 7.70.040 (describing manner of proving breach of standard of care); RCW 7.70.050 (describing manner of proving informed consent claim); RCW 7.70.070 (regarding court approval of attorney fees); RCW 7.70.080 (modifying collateral source rule); RCW 7.70.090 (limiting liability of hospital governing bodies); RCW 7.70.100(3) (mandating pretrial mediation); RCW 7.70.140 (closed claim reporting requirements).

⁹ Under RCW 26.44.030(8), a physician may provide “an expert medical opinion that child abuse, neglect, or sexual assault has occurred and that the child’s safety will be seriously endangered if returned home,” potentially triggering dependency proceedings. This provision seems to distinguish the obligation to report suspected child abuse, imposed on both health care providers and non-health care providers, from the use of a health care provider’s professional expertise to address an emergency situation. Otherwise, DSHS provides guidance to mandatory reporters in reporting suspected abuse, including 24-hour “expert medical consultation” for health care providers and others. See Dep’t of Social and Health Servs., Protecting the Abused & Neglected Child: A Guide for Mandated Reporters in Recognizing & Reporting Child Abuse & Neglect at 12 (Rev. 07/09) (available at <http://www.dshs.wa.gov/pdf/publications/22-163.pdf>; viewed Sept. 26, 2010).

Moreover, it is entirely conceivable that a health care provider could diagnose and treat a child in accordance with the standard of care imposed under Ch. 7.70 RCW, even with respect to health conditions traceable to child abuse, and yet still violate RCW 26.44.030 by not reporting suspected abuse. The parties' briefing in this case appears to be devoid of any indication whether the applicable standard of care under Ch. 7.70 RCW requires Tyler's health care providers to report the abuse he suffered. In any event, it is questionable whether that standard of care should dictate the reporting obligations for health care providers under RCW 26.44.030. Studies indicate that a significant percentage of physicians do not report child abuse even when they strongly suspect it.¹⁰

Assuming that the standard of care requires a health care provider to report child abuse, shoehorning failure-to-report claims into Ch. 7.70 RCW runs an unnecessary risk of compromising the policies underlying Ch. 26.44. RCW. The mandatory reporting statute is triggered whenever a

¹⁰ See Council on Science & Public Health, American Medical Association, Report No. 2: Identifying and Reporting Suspected Child Abuse, at 2:22 (Nov. 2009) (stating "a significant percentage of physicians do not report child abuse even when they strongly suspect it"); id. at 3:21-29 & nn.15-19 (summarizing research on physician reporting of child abuse); id. at 7:32-33 (concluding "many well-trained physicians are underreporting cases of suspected abuse"). This report made several recommendations, including a recommendation that the "American Medical Association [AMA] recognize that suspected child abuse is being underreported by physicians," and a recommendation that the "AMA support the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse." Id. at 7:45-49 & 8:7-9. The report was received and its recommendations were approved by the AMA House of Delegates at its 2009 Interim Meeting. A copy of the

health care provider “has reasonable cause to believe that a child has suffered abuse or neglect.” RCW 26.44.030(1)(a). In contrast, Ch. 7.70 RCW requires expert testimony to “a reasonable degree of medical certainty” to establish that the health care provider violated the applicable standard of care. See Reese v. Stroh, 128 Wn.2d 300, 309, 907 P.2d 282 (1995). Subjecting failure-to-report claims to this relatively more stringent standard could weaken the incentive to report abuse, and jeopardize the health and safety of Washington’s children – “the state’s greatest resource,” 1985 Laws ch. 259 § 1.¹¹

B. Under *Armijo*, The Wrongful Death And Survival Statutes Must Be Liberally Construed To Effectuate Their Remedial Purposes, And The Strict Construction Analysis In *Whittlesey* Has Been Abandoned.

The health care providers argue, based on Whittlesey v. Seattle, 94 Wash. 645, 163 Pac. 193 (1917), that the wrongful death and survival statutes’ dependent for support requirement must be strictly construed. See HCP Resp. Br. at 6. The question of strict versus liberal construction of these statutes is not addressed by Beggs. Yet, the Court’s resolution of the question whether Tyler DeLeon’s adoptive siblings were financially

report is included in the Appendix to this brief, and is also available online at: www.ama-assn.org/ama1/pub/upload/mm/443/csaph-report2-i09.pdf (viewed Sept. 23, 2010).

¹¹ Even if a health care provider’s failure to report suspected abuse were only actionable under Ch. 7.70 RCW, it is not a foregone conclusion that expert testimony would be required. See Berger, 144 Wn.2d at 110-11 & n. 100 (noting where expert testimony not required).

dependent on him for support, thereby qualifying as second tier beneficiaries under RCW 4.20.020, .046 and .060, may well be affected by the interpretive lens through which the Court views these statutes.¹²

Whittlesey, 94 Wash. at 647, did indeed embrace a strict construction, in analyzing the persons or classes of persons entitled to relief, and disallowing a wrongful death action by a widower when only widows were listed in the relevant statute, Rem. Rev. Code § 183. However, this Court has all but abandoned the Whittlesey approach, and embraced a broad rule of liberal construction of wrongful death and survival statutes.

An early indicator that the rule of strict construction announced in Whittlesey might not stand up is seen in Mitchell v. Rice, 183 Wash. 402, 48 P.2d 949 (1935), where the Court was reviewing the sufficiency of the evidence of dependency in the context of inconsistent jury verdicts. Without referencing Whittlesey, the Court noted that the dependent for support requirement should be interpreted in light of the statute's remedial character:

The degree of dependency required by the rule announced in the cases cited above is to be substantial. But "substantial" is a term having relation to the circumstances of the plaintiff. Also, we must not lose sight of the fact that the statute upon which the right of action is based is remedial in character. It creates a right of action not existing at

¹² The current versions of RCW 4.20.020, .046 and .060 are reproduced in the Appendix to this brief.

common law and should not, in its application, be so limited by construction as to partially defeat its purpose.

Mitchell, 183 Wash. at 407.

The force of Whittlesey was next eroded in Cook v. Rafferty, 200 Wash. 234, 93 P.2d 376 (1939), where the Court stated, again without reference to Whittlesey, that the then-current wrongful death and survival statutes “being remedial in their nature, are liberally construed” in connection with its assessment of the dependent for support requirement. See Cook, 200 Wash. at 240. While it might be argued that, consistent with Whittlesey, the Court only references liberal construction of the statutes insofar as the degree of dependency required, the statements in Mitchell and Cook seem much broader than that.

In any event, more recently in Armijo v. Wesselius, 73 Wn.2d 716, 720, 440 P.2d 71 (1968), the Court reexamined and distanced itself from the Whittlesey approach:

Respondents cite *Whittlesey v. Seattle*, 94 Wash. 645, 163 Pac. 193 (1917), for the rule that remedial statutes which are in derogation of the common law are to be strictly construed as to their classes of beneficiaries. It is contended that this rule forecloses Toni Marie’s chances of becoming a beneficiary under RCW 4.20.020, presumably on the theory that a strict construction of the words “child or children” would not include illegitimates. Respondents’ contention, however, is not persuasive. Whether done liberally or strictly, judicial interpretation is necessary even under respondents’ rule; illegitimate children are not *necessarily* excluded under the terms of RCW 4.20.020. This being so, we must still engage in a process of weighing and balancing competing values, and it appears to us that social policy

considerations favoring inclusion of illegitimate children as beneficiaries should be given effect. As stated in 3 J. Sutherland, *Statutory Construction*, §7205 (3d ed. 1943):

[M]any of the decisions in the past [construing wrongful death statutes], and a few of the later ones as well, have crippled the operation of this legislation by employing a narrow construction on the basis that these statutes are in derogation of the common law. However, it may now safely be asserted that the better and modern authorities are in agreement that the objectives and spirit of this legislation should not be thwarted by a technical application.

73 Wn.2d at 720.

The liberal construction applied in Armijo was reaffirmed by this Court in Klossner v. San Juan County, 93 Wn.2d 42, 46-48, 605 P.2d 330 (1980) (applying rule of liberal construction, but nonetheless holding that an unadopted stepchild does not come within the definition of “child” under RCW 4.20.020 and RCW 4.20.060). The dissent in Klossner also applied the rule of liberal construction in reaching a different conclusion. See id., 93 Wn.2d at 48-49 (Dolliver, J., dissenting). Most recently, the Court cited Armijo with approval in Armantrout v. Carlson, 166 Wn.2d 931, 941 n.1, 214 P.3d 914 (2009), although the Court found it unnecessary to choose between liberal or strict construction to resolve the issue presented in that case.

The Court should expressly overrule Whittlesey to the extent that it is inconsistent with the modern view expressed in Armijo and Klossner,

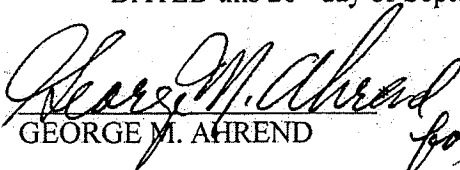
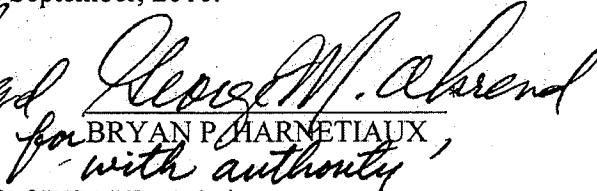
and disapprove of the Court of Appeals decisions following Whittlesey.¹³

To the extent necessary, the Court should also apply the rule of liberal construction in resolving the issue presented by this case.

VI. CONCLUSION

The Court should adopt the analysis set forth above on each issue, resolving this case accordingly.

DATED this 26th day of September, 2010.


GEORGE M. AHREND

for BRYAN P. HARNETIAUX
with authority
On behalf of WSAJ Foundation

*Brief transmitted for filing by email; signed original retained by counsel.

¹³ In addition to Roe v. Ludtke Trucking, Inc., 46 Wn.App. 816, 819, 732 P.2d 1021 (1987), cited by the health care providers, other Court of Appeals cases following Whittlesey include Masunaga v. Gapasin, 57 Wn.App. 624, 631, 790 P.2d 171 (citing Whittlesey and Roe), *review denied*, 115 Wn.2d 1012 (1990); Tait v. Wahl, 97 Wn.App. 765, 770, 987 P.2d 127 (1999) (citing Masunaga), *review denied*, 140 Wn.2d 1015 (2000); and Schumacher v. Williams, 107 Wn.App. 793, 797 & n.4, 28 P.3d 793 (2001) (citing Roe), *review denied*, 145 Wn.2d 1075 (2002).

Appendix

RCW 4.20.020. Wrongful death--Beneficiaries of action

Every such action shall be for the benefit of the wife, husband, state registered domestic partner, child or children, including stepchildren, of the person whose death shall have been so caused. If there be no wife, husband, state registered domestic partner, or such child or children, such action may be maintained for the benefit of the parents, sisters, or brothers, who may be dependent upon the deceased person for support, and who are resident within the United States at the time of his death.

In every such action the jury may give such damages as, under all circumstances of the case, may to them seem just.

[2007 c 156 § 29, eff. July 22, 2007; 1985 c 139 § 1; 1973 1st ex.s. c 154 § 2; 1917 c 123 § 2; RRS § 183-1.]

RCW 4.20.046. Survival of actions

(1) All causes of action by a person or persons against another person or persons shall survive to the personal representatives of the former and against the personal representatives of the latter, whether such actions arise on contract or otherwise, and whether or not such actions would have survived at the common law or prior to the date of enactment of this section: PROVIDED, HOWEVER, That the personal representative shall only be entitled to recover damages for pain and suffering, anxiety, emotional distress, or humiliation personal to and suffered by a deceased on behalf of those beneficiaries enumerated in RCW 4.20.020, and such damages are recoverable regardless of whether or not the death was occasioned by the injury that is the basis for the action. The liability of property of spouses or domestic partners held by them as community property to execution in satisfaction of a claim enforceable against such property so held shall not be affected by the death of either or both spouses or either or both domestic partners; and a cause of action shall remain an asset as though both claiming spouses or both claiming domestic partners continued to live despite the death of either or both claiming spouses or both claiming domestic partners.

(2) Where death or an injury to person or property, resulting from a wrongful act, neglect or default, occurs simultaneously with or after the death of a person who would have been liable therefor if his or her death had not occurred simultaneously with such death or injury or had not intervened between the wrongful act, neglect or default and the resulting death or injury, an action to recover damages for such death or injury may be maintained against the personal representative of such person.

[2008 c 6 § 409, eff. June 12, 2008; 1993 c 44 § 1; 1961 c 137 § 1.]

RCW 4.20.060. Action for personal injury survives to surviving spouse, state registered domestic partner, child, stepchildren, or heirs

No action for a personal injury to any person occasioning death shall abate, nor shall such right of action determine, by reason of such death, if such person has a surviving spouse, state registered domestic partner, or child living, including stepchildren, or leaving no surviving spouse, state registered domestic partner, or such children, if there is dependent upon the deceased for support and resident within the United States at the time of decedent's death, parents, sisters, or brothers; but such action may be prosecuted, or commenced and prosecuted, by the executor or administrator of the deceased, in favor of such surviving spouse or state registered domestic partner, or in favor of the surviving spouse or state registered domestic partner and such children, or if no surviving spouse or state registered domestic partner, in favor of such child or children, or if no surviving spouse, state registered domestic partner, or such child or children, then in favor of the decedent's parents, sisters, or brothers who may be dependent upon such person for support, and resident in the United States at the time of decedent's death.

[2007 c 156 § 30, eff. July 22, 2007; 1985 c 139 § 2; 1973 1st ex.s. c 154 § 3; 1927 c 156 § 1; 1909 c 144 § 1; Code 1881 § 18; 1854 p 220 § 495; RRS § 194.]

RCW 26.44.010. Declaration of purpose

The Washington state legislature finds and declares: The bond between a child and his or her parent, custodian, or guardian is of paramount

importance, and any intervention into the life of a child is also an intervention into the life of the parent, custodian, or guardian; however, instances of nonaccidental injury, neglect, death, sexual abuse and cruelty to children by their parents, custodians or guardians have occurred, and in the instance where a child is deprived of his or her right to conditions of minimal nurture, health, and safety, the state is justified in emergency intervention based upon verified information; and therefore the Washington state legislature hereby provides for the reporting of such cases to the appropriate public authorities. It is the intent of the legislature that, as a result of such reports, protective services shall be made available in an effort to prevent further abuses, and to safeguard the general welfare of such children: PROVIDED, That such reports shall be maintained and disseminated with strictest regard for the privacy of the subjects of such reports and so as to safeguard against arbitrary, malicious or erroneous information or actions: PROVIDED FURTHER, That this chapter shall not be construed to authorize interference with child-raising practices, including reasonable parental discipline, which are not proved to be injurious to the child's health, welfare and safety.

[1999 c 176 § 27; 1987 c 206 § 1; 1984 c 97 § 1; 1977 ex.s. c 80 § 24; 1975 1st ex.s. c 217 § 1; 1969 ex.s. c 35 § 1; 1965 c 13 § 1.]

RCW 26.44.020. Definitions

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Abuse or neglect" means sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW 9A.16.100; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section.

(2) "Child" or "children" means any person under the age of eighteen years of age.

(3) "Child protective services" means those services provided by the department designed to protect children from child abuse and neglect and safeguard such children from future abuse and neglect, and conduct investigations of child abuse and neglect reports. Investigations may be conducted regardless of the location of the alleged abuse or neglect. Child protective services includes referral to services to ameliorate conditions that endanger the welfare of children, the coordination of necessary programs and services relevant to the prevention, intervention, and treatment of child abuse and neglect, and services to children to ensure that each child has a permanent home. In determining whether protective services should be provided, the department shall not decline to provide such services solely because of the child's unwillingness or developmental inability to describe the nature and severity of the abuse or neglect.

(4) "Child protective services section" means the child protective services section of the department.

(5) "Clergy" means any regularly licensed or ordained minister, priest, or rabbi of any church or religious denomination, whether acting in an individual capacity or as an employee or agent of any public or private organization or institution.

(6) "Court" means the superior court of the state of Washington, juvenile department.

(7) "Department" means the state department of social and health services.

(8) "Founded" means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur.

(9) "Inconclusive" means the determination following an investigation by the department, prior to October 1, 2008, that based on available information a decision cannot be made that more likely than not, child abuse or neglect did or did not occur.

(10) "Institution" means a private or public hospital or any other facility providing medical diagnosis, treatment, or care.

(11) "Law enforcement agency" means the police department, the prosecuting attorney, the state patrol, the director of public safety, or the office of the sheriff.

(12) "Malice" or "maliciously" means an intent, wish, or design to intimidate, annoy, or injure another person. Such malice may be inferred from an act done in willful disregard of the rights of another, or an act wrongfully done without just cause or excuse, or an act or omission of duty betraying a willful disregard of social duty.

(13) "Negligent treatment or maltreatment" means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100. When considering whether a clear and present danger exists, evidence of a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight. The fact that siblings share a bedroom is not, in and of itself, negligent treatment or maltreatment. Poverty, homelessness, or exposure to domestic violence as defined in RCW 26.50.010 that is perpetrated against someone other than the child does not constitute negligent treatment or maltreatment in and of itself.

(14) "Pharmacist" means any registered pharmacist under chapter 18.64 RCW, whether acting in an individual capacity or as an employee or agent of any public or private organization or institution.

(15) "Practitioner of the healing arts" or "practitioner" means a person licensed by this state to practice podiatric medicine and surgery, optometry, chiropractic, nursing, dentistry, osteopathic medicine and surgery, or medicine and surgery or to provide other health services. The term "practitioner" includes a duly accredited Christian Science practitioner. A person who is being furnished Christian Science treatment by a duly accredited Christian Science practitioner will not be considered, for that reason alone, a neglected person for the purposes of this chapter.

(16) "Professional school personnel" include, but are not limited to, teachers, counselors, administrators, child care facility personnel, and school nurses.

(17) "Psychologist" means any person licensed to practice psychology under chapter 18.83 RCW, whether acting in an individual capacity or as an employee or agent of any public or private organization or institution.

(18) "Screened-out report" means a report of alleged child abuse or neglect that the department has determined does not rise to the level of a credible report of abuse or neglect and is not referred for investigation.

(19) "Sexual exploitation" includes: (a) Allowing, permitting, or encouraging a child to engage in prostitution by any person; or (b) allowing, permitting, encouraging, or engaging in the obscene or pornographic photographing, filming, or depicting of a child by any person.

(20) "Sexually aggressive youth" means a child who is defined in RCW 74.13.075(1)(b) as being a sexually aggressive youth.

(21) "Social service counselor" means anyone engaged in a professional capacity during the regular course of employment in encouraging or promoting the health, welfare, support, or education of children, or providing social services to adults or families, including mental health, drug and alcohol treatment, and domestic violence programs, whether in an individual capacity, or as an employee or agent of any public or private organization or institution.

(22) "Supervising agency" means an agency licensed by the state under RCW 74.15.090 or an Indian tribe under RCW 74.15.190 that has entered

into a performance-based contract with the department to provide child welfare services.

(23) "Unfounded" means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur.

(24) "Children's advocacy center" means a child-focused facility in good standing with the state chapter for children's advocacy centers and that coordinates a multidisciplinary process for the investigation, prosecution, and treatment of sexual and other types of child abuse. Children's advocacy centers provide a location for forensic interviews and coordinate access to services such as, but not limited to, medical evaluations, advocacy, therapy, and case review by multidisciplinary teams within the context of county protocols as defined in RCW 26.44.180 and 26.44.185.

[2010 c 176 § 1, eff. June 10, 2010; 2009 c 520 § 17, eff. July 26, 2009; 2007 c 220 § 1, eff. Oct. 1, 2008; 2006 c 339 § 108, eff. Jan. 1, 2007; (2006 c 339 § 107 expired January 1, 2007); 2005 c 512 § 5, eff. Jan. 1, 2007; 2000 c 162 § 19; 1999 c 176 § 29; 1998 c 314 § 7. Prior: 1997 c 386 § 45; 1997 c 386 § 24; 1997 c 282 § 4; 1997 c 132 § 2; 1996 c 178 § 10; prior: 1993 c 412 § 12; 1993 c 402 § 1; 1988 c 142 § 1; prior: 1987 c 524 § 9; 1987 c 206 § 2; 1984 c 97 § 2; 1982 c 129 § 6; 1981 c 164 § 1; 1977 ex.s. c 80 § 25; 1975 1st ex.s. c 217 § 2; 1969 ex.s. c 35 § 2; 1965 c 13 § 2.]

RCW 26.44.030. Reports--Duty and authority to make--Duty of receiving agency--Duty to notify--Case planning and consultation--Penalty for unauthorized exchange of information--Filing dependency petitions--Investigations--Interviews of children--Records--Risk assessment process

(1)(a) When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff,

HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(b) When any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency, provided that the person alleged to have caused the abuse or neglect is employed by, contracted by, or volunteers with the organization and coaches, trains, educates, or counsels a child or children or regularly has unsupervised access to a child or children as part of the employment, contract, or voluntary service. No one shall be required to report under this section when he or she obtains the information solely as a result of a privileged communication as provided in RCW 5.60.060.

Nothing in this subsection (1)(b) shall limit a person's duty to report under (a) of this subsection.

For the purposes of this subsection, the following definitions apply:

(i) "Official supervisory capacity" means a position, status, or role created, recognized, or designated by any nonprofit or for-profit organization, either for financial gain or without financial gain, whose scope includes, but is not limited to, overseeing, directing, or managing another person who is employed by, contracted by, or volunteers with the nonprofit or for-profit organization.

(ii) "Regularly exercises supervisory authority" means to act in his or her official supervisory capacity on an ongoing or continuing basis with regards to a particular person.

(c) The reporting requirement also applies to department of corrections personnel who, in the course of their employment, observe offenders or the children with whom the offenders are in contact. If, as a result of observations or information received in the course of his or her employment, any department of corrections personnel has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall

report the incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(d) The reporting requirement shall also apply to any adult who has reasonable cause to believe that a child who resides with them, has suffered severe abuse, and is able or capable of making a report. For the purposes of this subsection, "severe abuse" means any of the following: Any single act of abuse that causes physical trauma of sufficient severity that, if left untreated, could cause death; any single act of sexual abuse that causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness.

(e) The reporting requirement also applies to guardians ad litem, including court-appointed special advocates, appointed under Titles 11, 13, and 26 RCW, who in the course of their representation of children in these actions have reasonable cause to believe a child has been abused or neglected.

(f) The report must be made at the first opportunity, but in no case longer than forty-eight hours after there is reasonable cause to believe that the child has suffered abuse or neglect. The report must include the identity of the accused if known.

(2) The reporting requirement of subsection (1) of this section does not apply to the discovery of abuse or neglect that occurred during childhood if it is discovered after the child has become an adult. However, if there is reasonable cause to believe other children are or may be at risk of abuse or neglect by the accused, the reporting requirement of subsection (1) of this section does apply.

(3) Any other person who has reasonable cause to believe that a child has suffered abuse or neglect may report such incident to the proper law enforcement agency or to the department of social and health services as provided in RCW 26.44.040.

(4) The department, upon receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means or who has been subjected to alleged sexual abuse, shall report such incident to the proper law enforcement agency. In emergency

cases, where the child's welfare is endangered, the department shall notify the proper law enforcement agency within twenty-four hours after a report is received by the department. In all other cases, the department shall notify the law enforcement agency within seventy-two hours after a report is received by the department. If the department makes an oral report, a written report must also be made to the proper law enforcement agency within five days thereafter.

(5) Any law enforcement agency receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means, or who has been subjected to alleged sexual abuse, shall report such incident in writing as provided in RCW 26.44.040 to the proper county prosecutor or city attorney for appropriate action whenever the law enforcement agency's investigation reveals that a crime may have been committed. The law enforcement agency shall also notify the department of all reports received and the law enforcement agency's disposition of them. In emergency cases, where the child's welfare is endangered, the law enforcement agency shall notify the department within twenty-four hours. In all other cases, the law enforcement agency shall notify the department within seventy-two hours after a report is received by the law enforcement agency.

(6) Any county prosecutor or city attorney receiving a report under subsection (5) of this section shall notify the victim, any persons the victim requests, and the local office of the department, of the decision to charge or decline to charge a crime, within five days of making the decision.

(7) The department may conduct ongoing case planning and consultation with those persons or agencies required to report under this section, with consultants designated by the department, and with designated representatives of Washington Indian tribes if the client information exchanged is pertinent to cases currently receiving child protective services. Upon request, the department shall conduct such planning and consultation with those persons required to report under this section if the department determines it is in the best interests of the child. Information considered privileged by statute and not directly related to reports required by this section must not be divulged without a valid written waiver of the privilege.

(8) Any case referred to the department by a physician licensed under chapter 18.57 or 18.71 RCW on the basis of an expert medical opinion that child abuse, neglect, or sexual assault has occurred and that the child's safety will be seriously endangered if returned home, the department shall file a dependency petition unless a second licensed physician of the parents' choice believes that such expert medical opinion is incorrect. If the parents fail to designate a second physician, the department may make the selection. If a physician finds that a child has suffered abuse or neglect but that such abuse or neglect does not constitute imminent danger to the child's health or safety, and the department agrees with the physician's assessment, the child may be left in the parents' home while the department proceeds with reasonable efforts to remedy parenting deficiencies.

(9) Persons or agencies exchanging information under subsection (7) of this section shall not further disseminate or release the information except as authorized by state or federal statute. Violation of this subsection is a misdemeanor.

(10) Upon receiving a report of alleged abuse or neglect, the department shall make reasonable efforts to learn the name, address, and telephone number of each person making a report of abuse or neglect under this section. The department shall provide assurances of appropriate confidentiality of the identification of persons reporting under this section. If the department is unable to learn the information required under this subsection, the department shall only investigate cases in which:

(a) The department believes there is a serious threat of substantial harm to the child;

(b) The report indicates conduct involving a criminal offense that has, or is about to occur, in which the child is the victim; or

(c) The department has a prior founded report of abuse or neglect with regard to a member of the household that is within three years of receipt of the referral.

(11)(a) For reports of alleged abuse or neglect that are accepted for investigation by the department, the investigation shall be conducted within time frames established by the department in rule. In no case shall the investigation extend longer than ninety days from the date the report is

received, unless the investigation is being conducted under a written protocol pursuant to RCW 26.44.180 and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary. At the completion of the investigation, the department shall make a finding that the report of child abuse or neglect is founded or unfounded.

(b) If a court in a civil or criminal proceeding, considering the same facts or circumstances as are contained in the report being investigated by the department, makes a judicial finding by a preponderance of the evidence or higher that the subject of the pending investigation has abused or neglected the child, the department shall adopt the finding in its investigation.

(12) In conducting an investigation of alleged abuse or neglect, the department or law enforcement agency:

(a) May interview children. The interviews may be conducted on school premises, at day-care facilities, at the child's home, or at other suitable locations outside of the presence of parents. Parental notification of the interview must occur at the earliest possible point in the investigation that will not jeopardize the safety or protection of the child or the course of the investigation. Prior to commencing the interview the department or law enforcement agency shall determine whether the child wishes a third party to be present for the interview and, if so, shall make reasonable efforts to accommodate the child's wishes. Unless the child objects, the department or law enforcement agency shall make reasonable efforts to include a third party in any interview so long as the presence of the third party will not jeopardize the course of the investigation; and

(b) Shall have access to all relevant records of the child in the possession of mandated reporters and their employees.

(13) If a report of alleged abuse or neglect is founded and constitutes the third founded report received by the department within the last twelve months involving the same child or family, the department shall promptly notify the office of the family and children's ombudsman of the contents of the report. The department shall also notify the ombudsman of the disposition of the report.

(14) In investigating and responding to allegations of child abuse and neglect, the department may conduct background checks as authorized by state and federal law.

(15) The department shall maintain investigation records and conduct timely and periodic reviews of all founded cases of abuse and neglect. The department shall maintain a log of screened-out nonabusive cases.

(16) The department shall use a risk assessment process when investigating alleged child abuse and neglect referrals. The department shall present the risk factors at all hearings in which the placement of a dependent child is an issue. Substance abuse must be a risk factor. The department shall, within funds appropriated for this purpose, offer enhanced community-based services to persons who are determined not to require further state intervention.

(17) Upon receipt of a report of alleged abuse or neglect the law enforcement agency may arrange to interview the person making the report and any collateral sources to determine if any malice is involved in the reporting.

(18) Upon receiving a report of alleged abuse or neglect involving a child under the court's jurisdiction under chapter 13.34 RCW, the department shall promptly notify the child's guardian ad litem of the report's contents. The department shall also notify the guardian ad litem of the disposition of the report. For purposes of this subsection, "guardian ad litem" has the meaning provided in RCW 13.34.030.

[2009 c 480 § 1, eff. July 26, 2009; 2008 c 211 § 5, eff. Oct. 1, 2008; (2008 c 211 §4 expired October 1, 2008). Prior: 2007 c 387 § 3, eff. July 22, 2007; 2007 c 220 § 2, eff. Oct. 1, 2008; 2005 c 417 § 1, eff. July 24, 2005; 2003 c 207 § 4, eff. July 27, 2003; prior: 1999 c 267 § 20; 1999 c 176 § 30; 1998 c 328 § 5; 1997 c 386 § 25; 1996 c 278 § 2; 1995 c 311 § 17; prior: 1993 c 412 § 13; 1993 c 237 § 1; 1991 c 111 § 1; 1989 c 22 § 1; prior: 1988 c 142 § 2; 1988 c 39 § 1; prior: 1987 c 524 § 10; 1987 c 512 § 23; 1987 c 206 § 3; 1986 c 145 § 1; 1985 c 259 § 2; 1984 c 97 § 3; 1982 c 129 § 7; 1981 c 164 § 2; 1977 ex.s. c 80 § 26; 1975 1st ex.s. c 217 § 3; 1971 ex.s. c 167 § 1; 1969 ex.s. c 35 § 3; 1965 c 13 § 3.]

**RCW 26.44.060. Immunity from civil or criminal liability--
Confidential communications not violated--Actions against state not
affected--False report, penalty**

(1)(a) Except as provided in (b) of this subsection, any person participating in good faith in the making of a report pursuant to this chapter or testifying as to alleged child abuse or neglect in a judicial proceeding shall in so doing be immune from any liability arising out of such reporting or testifying under any law of this state or its political subdivisions.

(b) A person convicted of a violation of subsection (4) of this section shall not be immune from liability under (a) of this subsection.

(2) An administrator of a hospital or similar institution or any physician licensed pursuant to chapters 18.71 or 18.57 RCW taking a child into custody pursuant to RCW 26.44.056 shall not be subject to criminal or civil liability for such taking into custody.

(3) Conduct conforming with the reporting requirements of this chapter shall not be deemed a violation of the confidential communication privilege of RCW 5.60.060 (3) and (4), 18.53.200 and 18.83.110. Nothing in this chapter shall be construed as to supersede or abridge remedies provided in chapter 4.92 RCW.

(4) A person who, intentionally and in bad faith, knowingly makes a false report of alleged abuse or neglect shall be guilty of a misdemeanor punishable in accordance with RCW 9A.20.021.

(5) A person who, in good faith and without gross negligence, cooperates in an investigation arising as a result of a report made pursuant to this chapter, shall not be subject to civil liability arising out of his or her cooperation. This subsection does not apply to a person who caused or allowed the child abuse or neglect to occur.

[2007 c 118 § 1, eff. July 22, 2007; 2004 c 37 § 1, eff. June 10, 2004; 1997 c 386 § 29; 1988 c 142 § 3; 1982 c 129 § 9; 1975 1st ex.s. c 217 § 6; 1965 c 13 § 6.]

RCW 26.44.080. Violation--Penalty

Every person who is required to make, or to cause to be made, a report pursuant to RCW 26.44.030 and 26.44.040, and who knowingly fails to make, or fails to cause to be made, such report, shall be guilty of a gross misdemeanor.

[1982 c 129 § 10; 1971 ex.s. c 167 § 3.]

1985 Laws ch. 259 § 1

The Washington state legislature finds and declares:

The children of the state of Washington are the state's greatest resource and the greatest source of wealth to the state of Washington. Children of all ages must be protected from child abuse. Governmental authorities must give the prevention, treatment, and punishment of child abuse the highest priority, and all instances of child abuse must be reported to the proper authorities who should diligently and expeditiously take appropriate action, and child abusers must be held accountable to the people of the state for their actions.

The legislature recognizes the current heavy caseload of governmental authorities responsible for the prevention, treatment, and punishment of child abuse. The information obtained by child abuse reporting requirements, in addition to its use as a law enforcement tool, will be used to determine the need for additional funding to ensure that resources for appropriate governmental response to child abuse are available.

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-09)
Identifying and Reporting Suspected Child Abuse
(Resolution 426, A-08)
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. This report reviews the incidence of child abuse, current mandatory reporting requirements, physician compliance with reporting, current medical training on recognizing and reporting suspected child abuse, and common barriers to the reporting process. In addition the report notes solutions which have been proposed to address the current disparity between reporting requirements and compliance.

Data Sources. English-language articles were identified by a Medline search using the terms "child abuse," "child abuse reports," "mandatory reporting," "pediatricians," and "child maltreatment." Additional articles were identified by manual review of the references cited in these publications. The Web sites of the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry also were reviewed. In addition, pediatricians with expertise in child and adolescent trauma at Rush University Medical Center, La Rabida Hospital, Children's Memorial Hospital (all located in Chicago), and the Illinois Department of Children and Family Services were consulted. Finally, a Google search was conducted to further identify possible relevant information or articles on child abuse.

Results. Annually, nearly 3 million cases of suspected child abuse are reported to child protective services. Although physicians are required to report suspected cases of child abuse, several retrospective studies indicate physicians do not report all suspected cases of child abuse. Physicians are more likely to report a case if they perceive the injuries to be inconsistent with the medical history and if the patient was referred for suspected abuse. Variables influencing the decision to report include injury type, severity, and apparent family risk factors.

Several explanations have been advanced for physicians not reporting suspected abuse, including lack of training and clinical experience and gaps exist in medical school curricula and residency training. Other barriers to reporting include uncertainty surrounding HIPAA requirements, lack of clinical support services, and poor communication and collaboration among professionals who evaluate, investigate, and adjudicate child maltreatment.

Conclusions. Mandatory reporting laws do not specify what level of suspicion should trigger a report, only that it be reasonable. Nevertheless, many well-trained physicians are underreporting cases of suspected abuse. Rationales for this behavior include lack of trust in child protective services, concern about breaching the doctor/patient relationship, damaging the physician's relationship with the family, concern that no positive finding may be made, and the possibility of overzealous protective services' workers removing the child from the home when the physician (implicitly) does not believe this is indicated. An ongoing need exists for evidence-based clinical interventions and closer collaboration among all individuals and agencies involved in this process in order to ensure the ultimate victims receive the protections and services they need and deserve

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-09

Subject: Identifying and Reporting Suspected Child Abuse
(Resolution 426, A-08)

Presented by: C. Alvin Head, MD, Chair

Referred to: Reference Committee K
(Peter C. Amadio, MD, Chair)

Resolution 426, submitted by the Resident and Fellow Section and referred at the 2008 Annual Meeting, asked:

That our American Medical Association (AMA) support comprehensive reporting and investigation of all cases of reasonably suspected child abuse and neglect using an inclusive and interdisciplinary method in accordance with state and federal laws; and

That our AMA support the creation of a national standardized pediatric intentional trauma curriculum for medical students and residents.

Current Policy H-515.965 (AMA Policy Database) strongly supports mandatory reporting of suspected or actual child maltreatment and encourages state societies to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states. Furthermore, physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. Policy H-515.965 also notes that our AMA, working with state, county and specialty medical societies, as well as academic medical centers and other appropriate groups, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed.

Given that a significant percentage of physicians do not report child abuse even when they strongly suspect it, this report briefly reviews the incidence of child abuse, current mandatory reporting requirements, physician compliance with reporting, current medical training on recognizing and reporting suspected child abuse, and common barriers to the reporting process. In addition the report notes solutions which have been proposed to address the current disparity between reporting requirements and compliance, and also offers recommendations on how our AMA can advocate for improvements in identifying and reporting suspected child abuse. Although much of the published literature reviewed in this report is from pediatrics, the findings, implications, and recommendations of this report apply to emergency room physicians, family physicians, and other physicians who also may encounter suspected child abuse.

METHODS

English-language articles were identified by a Medline search using the terms "child abuse," "child abuse reports," "mandatory reporting," "pediatricians," and "child maltreatment."

Additional articles were identified by manual review of the references cited in these publications. The Web sites of the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry also were reviewed. In addition, pediatricians with expertise in child and adolescent trauma at Rush University Medical Center, La Rabida Hospital, Children's Memorial Hospital (all located in Chicago), and the Illinois Department of Children and Family Services were consulted. Finally, a Google search was conducted to further identify possible relevant information or articles on child abuse.

BACKGROUND

Scope of the Problem.

The National Incidence Study of Child Abuse and Neglect (NIS) gathers information from multiple sources to estimate the number of children who are abused or neglected, providing information about the nature and severity of the maltreatment, and characteristics of the children, perpetrators, and families. Based on the third NIS published more than 15 years ago, only 28% of child abuse or neglect cases were investigated. This study noted that the overall incidence of abuse increased by two-thirds between 1986 and 1993.¹ The fourth NIS is currently underway and will help establish the extent of changes in the incidence or epidemiology of child maltreatment since the third study was completed.

The Department of Health and Human Services in 2005 noted that more than six million children were reported as maltreated. This includes emotional neglect and abuse, physical abuse, sexual abuse, and medical neglect. In 2005, 2.9 million cases of suspected child abuse were reported to child protective services (CPS), even though a lack of consistent physician reporting exists.^{2,3} Among these reports, there were 825,000 indicated cases of abuse or neglect. It is estimated that approximately 1,500 children die annually as a result of abuse.³

Minorities are substantially overrepresented among those who have been reported; African American children are most frequently reported as victims of abuse. The degree to which racial bias in reporting and actual racial differences in child abuse explain this trend is not clear.⁴⁻⁷ Children who have caregivers with a history of substance use disorders or alcohol misuse are at increased risk, as are children living in a family with domestic violence occurring.⁸

Attempts have been made to evaluate the impact of child abuse on communities. Wolfe et al. developed a consensus framework involving factors contributing to harm, the role of community institutions such as hospitals, understanding the dimensions of harm, and physicians' concern about (apparent) betrayal of and diminished trust from their patient and the patient's family.⁹ A need for further assessment of policy and prevention initiatives exists in order to develop better safeguards in the community and to recognize vulnerabilities and risk factors related to abuse.⁹

MANDATORY REPORTING LAWS

In 1962, Kempe et al. first described the battered child syndrome and focused attention on public policy regarding child maltreatment in the United States.¹⁰ Initially, it was believed that the battered child syndrome likely affected only a few hundred children who were subjected to violent behavior by disturbed parents. However, it was soon recognized that a larger problem existed and to adequately address it would require health professionals to report suspected abuse to public authorities. By 1967, all 50 states had adopted mandatory reporting laws.^{11,12}

1 State eligibility for federal grants requires that they provide immunity to mandated reporters.¹³
 2 Every state provides immunity from civil and criminal liability for health care professionals who
 3 report suspected child abuse or neglect.¹³ Clear statutes exist that must be followed regarding
 4 mandatory reporting and immunity, most of which are based on a "reasonable cause to suspect"
 5 and "good faith" reporting. These statutes also provide a presumption of "good faith." That is, a
 6 person acting in good faith who makes a report, cooperates in an investigation, or assists in any
 7 other requirement for reporting child abuse is immune from civil or criminal liability that might
 8 otherwise be incurred by that action. A person making a report or assisting in any other
 9 requirement of the reporting requirement is presumed to have acted in good faith. In complying
 10 with state laws, the physician needs to report to the appropriate authorities and maintain some
 11 level of confidentiality. A few states (e.g., California, Tennessee) grant absolute immunity to
 12 mandated reporters. Under absolute immunity, a person cannot be held liable for reporting child
 13 abuse and for related testimony and communications with authorities.

14
 15 Most experts on child maltreatment believe mandated reporting is extremely important. Bringing
 16 abuse cases to public awareness continues to be in a child's best interest; otherwise these cases
 17 remain hidden.¹⁴

18 19 PHYSICIAN COMPLIANCE WITH REPORTING REQUIREMENTS

20
 21 Several retrospective studies indicate physicians do not report all suspected cases of child
 22 abuse.¹⁵⁻¹⁸ The Child Abuse Recognition Experience Study (CARES) gathered prospective data
 23 on how primary care providers decided whether injuries they encountered were caused by abuse,
 24 and whether they actually reported suspicious injuries to their state child protective services
 25 agency.¹⁹ This study involved 1,683 patients for whom primary care physicians (n = 327) had
 26 some level of suspicion that the child's injury was caused by child abuse. Only 6% of these cases
 27 were reported to the CPS. Physicians did not report 76% of the injuries they thought were
 28 possibly a result of abuse, and of even greater concern, did not report 27% of injuries considered
 29 "likely or very likely" to have been caused by child abuse.

30
 31 While physicians are not expected to report every child for whom they have any level of
 32 suspicion regarding physical abuse, more than one-quarter of cases in the CARES study were not
 33 reported even when the physician had a high degree of suspicion that the injury was caused by
 34 abuse. Physicians were more likely to report the case if they perceived the injuries to be
 35 inconsistent with the medical history and if the patient was referred to the clinician for suspected
 36 abuse. Cases most likely to be reported were those in which the patient: (1) had an injury other
 37 than a laceration; (2) had a serious injury; (3) had apparent family risk factors; (4) was black; or
 38 (5) was unfamiliar to the clinician.

39
 40 Mandatory reporting laws do not specify what level of suspicion should trigger a report, only that
 41 it be "reasonable." In a follow-up qualitative analysis of the physicians in the CARES study who
 42 concluded that the injury was suspicious and actually reported the injury to CPS, four major
 43 variables were described that influenced their decision to report: (1) familiarity with the family;
 44 (2) elements of the case history; (3) their use of available resources; and (4) their perception of
 45 expected outcomes after reporting to CPS.²⁰ Reporting is a complex issue, and different
 46 rationales exist for not reporting (see below). For many physicians, the decision to report is
 47 secondary not only to their clinical judgment, but also to their relationship with the family.

Reasons for Not Attributing and Reporting Injuries due to Child Abuse

Several explanations have been advanced for physicians not reporting suspected abuse. Many physicians feel inadequately trained to identify and manage child maltreatment. Although some physicians may knowingly not report suspected abuse, others may fail to identify child maltreatment, either because of insufficient knowledge or clinical experience, or because the case history itself is inadequate. Lack of training and clinical experience contributes to indecision about whether the child has been abused, and uncertainty about what actually must be reported. Even when evaluating sentinel events of physical abuse such as traumatic brain injury or femur fracture, physicians at community hospitals are less likely to report the case than physicians at pediatric specialty hospitals.²¹

Some physicians may not report suspected abuse, in part, because of confusion about the definition of abuse. Physicians have various views on what constitutes medical neglect, emotional neglect, and physical abuse. Research definitions categorizing the severity of abuse include (what may be termed) definitive abuse, likely abuse, questionable abuse vs. questionable unintentional injury, and likely and definitive unintentional injury. Leventhal et al. reviewed specific criteria for clinicians in an attempt to distinguish between abuse and unintentional injuries.²² Interestingly, definitions regarding sexual abuse are consistent, and this type of abuse also has the highest incidence of reporting.

Physicians' reluctance to report child abuse often reflects a belief that referral to CPS will not result in an effective (or even the "right") intervention.^{19,20,23} Distrust between physicians and CPS workers reflects a shared pattern of poor communication, faulty and biased interactions, lack of ongoing collaboration, and misunderstanding about confidentiality requirements. Reluctance to report also includes the possibility of irreparable harm to the doctor/patient/family relationship and undue disruption of the patient's family. Additionally, a belief may exist that the investigating agency will fail to corroborate the findings or, alternatively, may overreact to positive findings resulting in unnecessary transfer of the child to relatives or placement in a foster home. Previous negative experiences with CPS ultimately lead to fewer cases of suspected abuse and neglect being reported by physicians. Generally speaking, physicians believe that mandated reporting is imperfect, results in increased work loads for child protective services, is a potential waste of resources, and most importantly, may be associated with a poor quality of services provided to the children identified in the assessments.²⁴

Finally, some physicians may not report suspected child abuse because they are concerned that reporting will lead to involvement in court proceedings. In one study, 16% of physicians considered spending time in court as a negative outcome of reporting.¹⁶ However, in the CARES study, physicians were more likely to report suspected child abuse if they had previous experience in court.²⁰

Liability Concerns

As noted above, physician reporters are granted civil and criminal immunity when they comply with state statutes and report child abuse cases in good faith based on a reasonable level of suspicion. The key federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974 (Public Law 93-247). This Act has been amended and reauthorized several times, most recently by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36). CAPTA directs state programs to identify and report cases of abuse and provides federal funding to states in support of various activities related to child abuse. CAPTA also established the Office on Child Abuse and Neglect and mandates the

1 National Clearinghouse on Child Abuse and Neglect Information. Although CAPTA does not
 2 require states to punish individuals if they fail to report, all 50 states have criminal penalties for
 3 failure to report child abuse, and some have civil penalties as well.¹²

4
 5 The most common cause of liability exposure is a failure of physicians and hospitals to recognize
 6 abuse and/or fail to report recognized abuse.²⁶ Criminal liability also may be incurred for
 7 knowingly, or negligently, making a false report.^{12,26} Other types of situations such as voluntarily
 8 informing third parties (e.g., public officials, attorneys in child custody cases), or relying on third
 9 party allegations for decision-making may create incriminating circumstances.²⁶

10
 11 Thus, ramifications exist for physicians who do appropriately comply with mandatory reporting
 12 laws for child abuse. Although physicians may believe that they know what is best for the child
 13 and family, failure to report is generally not in the best interests of the child who has been abused.
 14 Failure to report child abuse or neglect can deny a child the social and protective interventions he
 15 or she may need. At present, it is likely that hundreds of thousands of children who are being
 16 abused or neglected are not receiving interventions through departments of protective services, in
 17 part, because health care professionals are not complying with legal mandates to report suspected
 18 child abuse and neglect.²⁷

19 20 TRAINING ACROSS THE CONTINUUM OF MEDICAL EDUCATION

21 22 *Medical Schools*

23
 24 Medical school students should be educated to be vigilant for possible child abuse and neglect.
 25 The LCME Accreditation Standards state "the curriculum must prepare students for their role in
 26 addressing the medical consequences of common societal problems, for example, providing
 27 instruction in the diagnosis, prevention, appropriate reporting and treatment of violence and
 28 abuse."²⁸ Although medical schools are supposed to teach about child maltreatment, many do
 29 not. Currently, the educational exposure for medical students on child maltreatment ranges from
 30 0 to 16 hours, with a median of 2 hours. Forty-one schools have preclinical instruction and 49
 31 have instruction during the pediatric clerkship, but 21% of medical schools have no required
 32 instruction.²⁹

33 34 *Residents*

35
 36 A 2006 survey of chief residents in pediatric residencies revealed that 25% of accredited pediatric
 37 residency programs do not offer rotations in child abuse and neglect and only 41% mandated such
 38 clinical experience.^{30,31} Nevertheless, a recent survey of pediatric, emergency medicine, and
 39 family medicine residents on their level of knowledge, comfort, and training related to the
 40 medical management of child abuse found that exposure to child abuse training and abused
 41 patients was highest for pediatric residents and lowest for family medicine residents.³² Overall,
 42 findings on residents' knowledge and clinical decision-making support the need for improved
 43 education in this sector.³³

44 45 *Physicians in Practice*

46
 47 Approaches to improve the training of practicing physicians as mandated reporters include Web-
 48 based continuing medical education (CME) programs on recognizing child maltreatment. Online
 49 tutorials can potentially help physicians better identify child abuse and understand the process of
 50 being a mandated reporter, including reporting to the appropriate department of protective
 51 services or other institutions.³⁴ A specific model program designed to educate physicians,

provide office tools, and promote interaction with child protective services is EPIC-SCAN (Educating Physicians in Their Communities on Suspected Child Abuse and Neglect). This is a statewide community-based CME program developed in Pennsylvania under the auspices of the Pennsylvania chapter of the American Academy of Pediatrics (AAP) and the Pennsylvania Department of Public Welfare.³⁵

SOLUTIONS TO LACK OF REPORTING

In response to the ongoing recognition that health care professionals are not adequately reporting suspected cases of child abuse to CPS, barriers to effective reporting and potential solutions were addressed by a multidisciplinary conference hosted by the American Academy of Pediatrics (see Appendix).³⁶ This conference, entitled Child Abuse, Recognition, Research, and Education Translation Conference (or CARRET) identified five strategies involving confidentiality regulations, development and support of multidisciplinary centers of excellence, regional solutions for sparsely populated areas, education across the continuum of professional development, and better training/collaboration among medical, law enforcement, and CPS professionals.³⁷ Within the latter domain, changing CPS procedures to require medical consultation for those specific allegations of abuse that include medical assessment, and reducing CPS workload to allow sufficient time for adequate investigation of suspected cases of abuse seem to be a necessary ancillary approach.²³

Typically, multidisciplinary teams in university-based hospitals are positioned to assess types of suspected abuse and determine the appropriateness of referrals to protective services. For example, in infants who have sustained trauma resulting in bone injuries it is often difficult to determine whether abuse should be suspected. These hospital-based programs can evaluate the complexities of these types of injuries.³⁸

In general, when a physician or mandated reporter suspects child abuse, he or she is mandated by law to report the case to CPS. If done appropriately, this is not a HIPAA violation. However, as noted in the CARRET conference, "hospitals have varying interpretation of how HIPAA applies to child abuse cases, which limits hospital-based personnel's ability to discuss cases with CPS. CPS regulations and practices vary according to locality, often preventing them from providing even the most basic feedback to mandated reporters concerning the outcome of their reports." Thus, it remains important to "clarify and expand confidentiality regulation to improve communication and collaboration between CPS workers and other professionals."³⁷

The AAP also has advanced the idea of a Child Abuse Research, Education and Service (CARES) Network which is a proposal for federal investment in a national health care infrastructure to reduce the health harms resulting from child abuse and neglect.³⁹

Departments of protective services have begun to develop solutions to address lack of reporting. These include the development of centers with areas of expertise on sexual abuse, physical abuse, and medical neglect. Many university-based emergency rooms have access to child abuse teams; physicians who are not certain of maltreatment in particular cases can refer those cases to a child abuse team for evaluation or consult with their local child abuse expert. This approach can foster the doctor/patient relationship and help to bring more objectivity to the process. Most importantly, this approach can provide safe and appropriate interventions for patients.

Child abuse may be easily overlooked within emergency rooms. Because emergency rooms, particularly in urban areas, can be extremely busy, child abuse cases can be missed. Minimally, there should be an abuse-specific checklist. Benger et al. described a 4-point checklist to include

in the medical notes when preschool-aged children present with thermal injuries (a common abuse-related injury). Use of this checklist improved awareness and documentation of intentional injuries, and increased referral rates.⁴⁰ In addition, quality improvement programs in community hospitals may be indicated to promote better identification.²¹

The American College of Emergency Physicians "encourages emergency personnel to assess patients for family violence in all its forms, including that directed toward children." Similar to the discussion noted above, ACEP acknowledges the: (1) need for standard education and training; (2) development of best practices for assessment and intervention; (3) use of collaborative interdisciplinary approaches; (4) development of working relationships with agencies that oversee investigation of family violence; and (5) appropriate education of hospital personnel on state legal requirements for reporting suspected cases of abuse and maltreatment.⁴¹

CONCLUSIONS

Child abuse is endemic. In the United States, focus on the issue began in the early 1960s and by 1967 all 50 states had mandatory reporting requirements. Importantly, physicians must understand that the intent of mandatory reporting is to protect the child. Even though a fellowship with certification in pediatrics for child abuse now exists, some debate continues within the discipline of child welfare on issues related to mandatory reporting, such as the relative role of reporting and investigation, and the overall effects of mandatory reporting on child welfare.⁴²

Although a common reason that physicians give for not reporting is uncertainty, the law does not require that they be certain, only that they have "reasonable suspicion to report." Some cases are clearly more straightforward, such as sexual abuse (which physicians report much more consistently). Suspected cases of physical abuse are more complicated based on the age of the patient and the type of trauma observed. Among the more difficult types of cases to assess are medical neglect and certain pathological types of abuse.

At the present time, training in recognizing and reporting child abuse varies among medical schools and residency programs. Nevertheless, many well-trained physicians are underreporting cases of suspected abuse. Rationales for this behavior include lack of trust in child protective services, concern about breaching the doctor/patient relationship, damaging the physician's relationship with the family, concern that no positive finding may be made, and the possibility of overzealous protective services' workers removing the child from the home when the physician (implicitly) does not believe this is indicated.

Finally, there is a need for ongoing evidence-based clinical interventions and closer collaboration among all individuals and agencies involved in this process in order to ensure the ultimate victims receive the protections and services they need and deserve.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 426 (A-08) and that the remainder of this report be filed.

1. That our American Medical Association (AMA) recognize that suspected child abuse is being underreported by physicians. (New HOD Policy)

- 1 2. That our AMA support development of a comprehensive educational strategy across the
2 continuum of professional development that is designed to improve the detection,
3 reporting, and treatment of child maltreatment. Training should include specific
4 knowledge about child protective services policies, services, impact on families, and
5 outcomes of intervention. (New HOD Policy)
6
- 7 3. That our AMA support the concept that physicians act as advocates for children, and as
8 such, have a responsibility legally and otherwise, to protect children when there is a
9 suspicion of abuse. (New HOD Policy)
10
- 11 4. That our AMA recognize the need for ongoing studies to better understand physicians
12 failure to recognize and report suspected child abuse. (New HOD Policy)
13
- 14 5. That our AMA acknowledge that conflicts often exist between physicians and child
15 protective services, and that physicians and child protective services should work more
16 collaboratively, including the joint development of didactic programs designed to foster
17 increased interaction and to minimize conflicts or distrust. (New HOD Policy)
18
- 19 6. That our AMA support efforts to develop multidisciplinary centers of excellence and
20 adequately trained clinical response teams to foster the appropriate evaluation, reporting,
21 management, and support of child abuse victims. (New HOD Policy)
22
- 23 7. That our AMA encourage all state departments of protective services to have a medical
24 director or other liaison who communicates with physicians and other health care
25 providers. (Directive to Take Action)
26
- 27 8. That our AMA reaffirm Policy H-515.965, which strongly supports mandatory reporting
28 of suspected child maltreatment. (Reaffirm HOD Policy)

Fiscal Note: \$5,000

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APPENDIX

Barriers that Impede Effective Protection of Children Who May Have Been Abused and Strategies for Addressing these Barriers

1. Barrier: Hospitals have varying interpretations of how the Health Insurance Portability and Accountability Act (HIPAA) applies in child abuse cases, which limits hospital-based personnel's ability to discuss cases with CPS. CPS regulations and practices vary according to locality, often preventing them from providing even the most basic feedback to mandated reporters concerning the outcome of their reports.

Solution: Clarify and expand confidentiality regulations to improve communication and collaboration between CPS workers and other professionals.

2. Barrier: Research has produced much new knowledge about the identification and management of child maltreatment. The expanding knowledge base has resulted in the development of a new subspecialty: child abuse pediatrics. In addition, because this expertise is needed, some hospitals have developed centers of excellence following guidelines published by the National Association of Children's Hospitals and Related Institutions (NACHRI). The American Academy of Pediatrics (AAP) has developed the Child Abuse Research, Education, and Service (CARES) Network proposal, which would provide federal support for centers of excellence.

Solution: Develop and support multidisciplinary centers of excellence that would provide consultation, referrals to other services in the community, research, surveillance, and training to support and provide resources to reporters.

3. Barrier: Some areas of the country are sparsely populated and cannot effectively utilize a full-time specialized child abuse team.

Solution: Develop more mobile methods and assemble regional service teams for assessment of possible child abuse and neglect.

4. Barrier: No standards specify the quantity or quality of education that medical students, pediatric residents, or other physicians should receive about child maltreatment. Many physicians indicate that they feel inadequately trained to identify and manage child maltreatment.

Solution: Develop a comprehensive educational strategy that builds knowledge and experience from medical school and residency through continuing education once a clinician is in practice, including segments that describe prevention, identification, and interaction with the state CPS system. Training should include specific knowledge about CPS policies, services, and outcomes of intervention.

5. Barrier: Poor communication and collaboration between the professionals who evaluate, investigate, and adjudicate child maltreatment can lead to ineffective or inappropriate intervention. Poor communication may result from the lack of understanding of the roles of the other professionals. This misunderstanding often includes unrealistic expectations about the power and scope of the other professional's work.

Solution: Clarify the roles of the different professionals who evaluate, investigate, and adjudicate child maltreatment. Encourage and facilitate collaboration between medical, law enforcement, and CPS by including the other professionals in the training to explain their respective roles. One example of how this strategy could be implemented is Pennsylvania's EPIC program. In the EPIC training, CPS workers participate in physician training about child maltreatment.

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Subject: Beggs, et al. v. Fregeau, et al., (S.C. #84098-9)

Dear Mr. Carpenter:

On behalf of the Washington State Association for Justice Foundation, a letter application for amicus curiae status, along with a proposed amicus curiae brief, are attached to this email. Counsel are being served simultaneously with copies of both documents by email by prior agreement.

--
George Ahrend
Ahrend Law Firm PLLC
100 E. Broadway Ave.
Moses Lake, WA 98837
Work: (509) 764-9000
Cell: (509) 237-1339
Fax: (509) 464-6290

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